CHAPTER 9
SECTION 2

REPORTING REQUIREMENTS

1.0. REPORTING REQUIREMENTS AND OTHER REQUIREMENTS

1.1. DEERS Discrepancy Report

The contractor will report to DEERS information on claims for which the DEERS response is overridden in accordance with the requirements of the Fiscal Intermediary Discrepancy Reporting System (FIDRS). The Discrepancy File is sent on magnetic tape monthly to the EDS Tape Library, 13600 EDS Drive, Herndon, VA 22071, DEERS will research each discrepancy. The Form 88R is used to report discrepancies not handled via the monthly tape, and should be sent with accompanying backup documents to the DEERS Support Office, 2511 Garden Road, Suite 260A, Monterey, CA 93940. Refer to Section 5 of this chapter for further information.

1.2. Adjustment Processing

If DEERS determines that the original response was correct, even though the contractor has overridden the response based on their application of the instructions of this chapter, the contractor shall process an adjustment if the claim was partially paid or reprocessed as a new claim subsequent to being totally denied. The adjustment will be considered a non-contractor error if procedures prescribed by TRICARE Management Activity (TMA) and DEERS have been followed.

2.0. PAYMENT RECORD REQUIREMENTS

Claims delayed because of development of the DEERS response will be identified by the appropriate claims delay flag code. Claims denied because DEERS indicated the claimant was ineligible (whether development was required or not) will be identified by the appropriate reject or reason / pricing code. The contractor will code the data from the claim whenever there is a difference between the claim data and DEERS data.

3.0. INFORMING THE PATIENT, SPONSOR, OR PROVIDER OF CLAIMS DENIAL OR DEERS DATA BASE PROBLEMS

If all or part of the claim is to be denied because of DEERS, the contractor shall annotate on the EOB with the appropriate action message. The EOB must also include information when DEERS is either incorrect or incomplete and the claim is to be paid. For example, the EOB shall inform the patient or sponsor that the ID card has expired according to DEERS, even if the claim is paid. In addition, the EOB must always inform the sponsor to enroll his or her family members whenever the patient or the sponsor is not on DEERS, even if the claim is paid (e.g., newborns).

4.0. VERIFIED INFORMATION

The following is considered valid information for overriding a DEERS reply.

4.1. Copies of the patient's Notice of Disallowance when DEERS indicates ineligible and the patient is over 65.

4.2. Copies of retirement papers in combination with a photocopy of the patient's identification card when the sponsor is not on DEERS.

4.3. Copies of active duty orders in combination with a photocopy of the patient's identification card when the sponsor is not on DEERS.

4.4. Letters of disallowance must specifically address eligibility as it relates to "Hospital" (Part A) Medicare. The term "Medical" benefit does not refer to Medicare, Part A, and does not apply.

4.5. Copies of retirement papers in combination with a photocopy of the patient's identification card when DEERS indicates the sponsor is on active duty and claim is for the sponsor.

4.6. A photocopy of the patient's identification card (or parent's ID for family member children under age 10) when DEERS indicates a reason for change code of E, ID Card Expired Beyond Prescribed Limits.

4.7. Copies of the patient's Medicare card establishing eligibility for Medicare, Part A, when DEERS indicates TRICARE eligible and the patient is under 65 years of age.

4.8. Copies of the patient's Medicare card establishing eligibility for Medicare, Part A, when DEERS indicates TRICARE eligible and the patient is over 65 years of age.

4.9. Claim form or other Service documentation (ID Card, promotion / demotion papers) which indicate that the active duty sponsor's pay grade / rank is different from that reported on DEERS.

5.0. RECOUPMENT PROCEDURES FOR PRIOR CLAIMS

5.1. The contractor is to examine the most current 12 months of history for any claims paid to ineligible patients, whether the patient is determined to be ineligible because the sponsor is not on DEERS, the patient is not on DEERS or the person is ineligible on DEERS. History is only to be examined if the current claim is being denied in accordance with the requirements in this section.

5.2. If the current claim is being denied because the sponsor is not on DEERS, no action is required until the discrepancy record is processed by the DEERS Support Office and their reply indicates the sponsor is not an eligible sponsor. Should this occur, the most current 12 months of history will be examined.

5.3. If the current claim is being denied because the patient is not on DEERS, no discrepancy reporting is required. Should this occur, the most current 12 months of history will be examined.

5.4. If the current claim is being denied because the patient is ineligible because the entitlement dates are outside the treatment period or the patient has no TRICARE privileges, the contractor shall examine the most current 12 months of history. Since DEERS will provide the beginning and ending eligibility dates, the contractor will be able to identify claims paid for services provided before entitlement began or after the entitlement ended.

5.5. CHAMPVA claims shall be forwarded to Health Administration Center, CHAMPVA Program P.O. Box 65024, Denver CO 80206-5024.

6.0. HANDLING EXCEPTIONS REFERRED BY DEERS PROGRAM OFFICE, DEERS SUPPORT OFFICE, AND UNIFORMED SERVICE DEERS PROJECT OFFICERS

A list of key DEERS Program Office, DEERS Support Office, and Uniformed Service Project Officers is provided in Addendum D. These individuals have been designated by TRICARE Management Activity (TMA) and DEERS to assist DoD beneficiaries in handling cases referred by higher authorities or the Congress regarding payment of TRICARE claims and overriding information in the DEERS data base. When contacted by one of these individuals, either in writing or by telephone, the contractor will provide priority handling of any claims referred by them and process the claims requested by the individual. Situations requiring such actions by the contractor should not occur frequently and only when the DEERS data base is incomplete or incorrect. The contractor will provide any necessary support to these individuals to assist them in the performance of their duties. When an override is performed, a written notice will be sent by DEERS to the beneficiary. The contractor shall also use a verbal override to update their files. The override will act as a substitute for the missing documentation for processing all future claims as well as the claim(s) in question. An example would be an override for a Notice of Disallowance for a beneficiary over age 65 who is Medicare ineligible. Since the contractor will be able to accept the overrides verbally, it is mandatory that the contractor maintain a log of the person authorizing the override along with the date and type of override authorized. The contractor shall only provide special support to the individuals listed in Addendum D (or his or her replacement).

7.0. PROCESSING NONAVAILABILITY STATEMENT (NAS) DATA ON DEERS

7.1. General

Inpatient Nonavailability Statement (INAS) processing is required for all programs except those specified by the Policy Manual, Chapter 11, Section 2.1. The requirements outlined in the OPM Part Two, Chapter 1, Section IV.G., apply. The automated INAS policy applies to all 50 states, the District of Columbia, and Puerto Rico. Foreign claims requiring an INAS shall be processed with a copy of the DD Form 1251 attached to the claim form.

NOTE: When NAS appears in the text, it refers to both INASs and ONASs for services furnished prior to September 23, 1996.

7.2. Contractor Query

NOTE: For maternity care episodes beginning on or after March 26, 1998, the hospital admission date listed on the nonavailability statement must be within 30 days of the issue date. Nonavailability statements are no longer required for outpatient prenatal or postpartum care.

7.2.1. Whenever an INAS is required for claim payment, the query sent to DEERS shall contain a '1' in the "NAS Required Indicator" field. When an ONAS is required for claim payment, the query sent to DEERS shall contain a '2' in the "NAS Required Indicator" field. If an INAS or ONAS is not required, the query shall contain a '0' in the "NAS Required Indicator" field.

7.2.2. If an INAS is required, the contractor shall include the date of the hospital admission or, for maternity care episodes which began prior to March 26, 1998, the date of the first prenatal maternity care visit must be entered. The date of admission must be coded, if the claim is from the institutional provider or the attending physician.

7.2.3. The contractor shall attempt to retrieve the date of admission from history or previously submitted claims for all other claims associated with the inpatient admission or match the DEERS query each time a claim is submitted, depending on which method is more cost effective. The hospital admission date must be within 30 days from the issue date, EXCEPT for chronic care cases or for maternity episodes which began prior to March 25, 1998. In maternity cases which began prior to March 26, 1998, the first prenatal visit date must be the same as the issue date within the "NAS Number" field or must be the same date as the retroactive date on retroactive issuances. The NAS Number, Major Diagnostic Category, and Reason For Issuance fields must be downloaded from DEERS unless a paper copy is attached to the claim or is on file with the provider.

7.3. DEERS Reply

7.3.1. General

7.3.1.1. Two types of NAS issuances, either unconditional or cancelled, can appear in the "NAS Status" field of the query response. The majority of NASs issued will appear as unconditional. A cancelled NAS is one that was issued and subsequently cancelled. A cancelled NAS shall not be used for claims processing. When the status field indicates a cancelled NAS, the contractor shall deny any outstanding claim. The contractor shall also check for prior claims paid on the cancelled NAS and recoup any monies paid in error.

7.3.1.2. If the DEERS eligibility response code is '01' through '11', no NAS information will be included in the response.

7.3.1.3. The contractor shall process the claim using the NAS data on the DEERS reply in the same manner as it would process the claim using a hardcopy NAS form.

7.3.2. INAS Response

7.3.2.1. When DEERS has INAS data that support the INAS request in the contractor query (or any on file when the date of admission is blank), the reply will contain the INAS

number, major diagnostic category, NAS status, reason for issuance, access counter, and other health insurance indicator. DEERS will return this information for any and all INASs on its file for which the claim could apply. DEERS will select the appropriate INAS for the reply by comparing the hospital admission date supplied by the contractor to the issue date (in Julian format) within the "NAS Number" field on the DEERS data base.

7.3.2.2. When INAS data are included in the DEERS response record, DEERS will return a '1' in the "NAS Required Indicator" field on the DEERS response. The "NAS Segment Count" field will indicate the number of INASs appended to the record. A maximum of 45 INASs per family member can be included in the record.

7.3.2.3. The DEERS response will contain all INAS information for the family member in date-order sequence with the most recently issued INAS appearing first. If the hospital admission date, or, for maternity episodes which began prior to March 26, 1998, the first prenatal visit date is not included in the contractor query, the contractor is responsible for making date comparisons to select the proper INAS.

7.3.2.4. On retroactive INASs, including INASs for maternity care episodes beginning on or after March 26, 1996, the "Retroactive Date" on the DEERS response screen shall be the hospitalization date, or, for maternity care episodes which began prior to March 26, 1998, the first prenatal visit date. A retroactive INAS will have an NAS number sequence between 900 and 999. (Refer to the Type 3 DEERS response of this chapter.) It will also have a retroactive effective date that is separate from the INAS issuance date located within the INAS number. The retroactive effective date will show the beginning date of the effective period of the INAS. The contractor is not responsible for performing any consistency edits on the INAS number and the retroactive effective date.

7.3.2.5. A retroactive maternity INAS will be identified by the retroactive effective date (for maternity episodes which began prior to March 26, 1998, the first prenatal visit date) and by the major diagnostic category 14. This INAS will be valid 42 days beyond the termination of the pregnancy.

7.3.2.6. If the newborn remains in the hospital continuously after the mother's discharge, the mother's INAS will cover the infant in the same hospital for up to 15 days following the mother's discharge. Beyond the 15th day, the infant requires an INAS in his/her own right.

7.3.2.7. When a newborn requires an INAS in his/her own right, the MTF will issue the newborn's INAS retroactive to the baby's date of birth. The contractor will only need to query for the baby's INAS, instead of querying for both the mother and the child.

7.3.2.8. For all chronic care-retroactive INAS issuances, the last three digits of the INAS number will be between 700-799.

7.3.2.9. For all chronic care INAS issuances, the last three digits of the assigned INAS number will be between 800-899. (Refer to the Type 3 DEERS response of this chapter.) All chronic care INAS issuances will be valid for one year from the date of issuance.

7.3.3. ONAS Response

NOTE: ONAS requirements apply to services provided from October 1, 1991, through September 22, 1996, only.

7.3.3.1. When DEERS has ONAS data that supports the ONAS request in the contractor query, the reply will contain the ONAS number, 2-digit code for the "Selected Outpatient Procedure Code" category, NAS status, reason for issuance, access counter, and other health insurance indicator. DEERS will return this information for any and all ONASs on its file for which the claim could apply. DEERS selects the appropriate ONASs in date order sequence by the most recently issued (in Julian format) within the "NAS Number" field. It is the contractor's responsibility to match the closest issuance date within the "NAS Number" field to the treatment date on the claim form. All ONASs are issued for 30 days. In each instance, the treatment date on the claim form must be within the effective window period (30 days) to be matched to the ONAS.

7.3.3.2. When ONAS data is included in the DEERS response record, DEERS will return a '2' in the "NAS Required Indicator" field on the DEERS response. The "NAS Segment Count" field will indicate the number of ONASs appended to the record. A maximum of 45 ONASs per family member can be included in the record.

7.3.3.3. On retroactive ONASs, the "Retroactive Date" field must be the same as the treatment date on the claim form.

7.4. Contractor NAS Report

Effective July 31, 1990, this report is no longer required.

7.5. NAS Override Authority

The persons listed in Addendum D of this chapter have NAS override authority for unusual cases.

8.0. MANAGED CARE ENROLLMENT REPORTING PROCEDURES

8.1. Network Primary Care Manager Selections

8.1.1. Prime enrollees selecting a network primary care manager must be updated in DEERS with the 6900 series network DMIS-ID corresponding to the enrollment region as follows:

PRIME NETWORK ENROLLMENT	
REGION	DMIS-ID
Region 1	6901, 8000-8099
Region 2	6501[1], 6902, 8000-8099

[1] 6501 valid through 9/30/99.

PRIME NETWORK ENROLLMENT (CONTINUED)	
REGION	DMIS-ID
Region 3	6903
Region 4	6904
Region 5	6905, 8000-8099
Region 6	6906
Region 7	6907
Region 8	6908
Region 9	6909
Region 10	6910
Region 11	6911
Region 12	6912
Region 13	6913
Region 14	6914
Region 15	6915
[1] 6501 valid through 9/30/99.	

TRICARE PRIME REMOTE	
REGION	DMIS-ID
Region 1	7901, 8000-8099
Region 2	7902, 8000-8099
Region 3	7903
Region 4	7904
Region 5	7905, 8000-8099
Region 6	7906
Region 7	7907
Region 8	7908
Region 9	7909
Region 10	7910
Region 11	7911
Region 12	7912, 7916
[1] All regions can have blank DMIS-ID through 9/30/99. [2] DMIS-ID 6911 is valid for TPR in region 11 through 9/30/99.	

8.1.2. The PCM Location Code will require mandatory entry of '01' for network primary care providers. There will be no default to spaces.

8.2. Military Treatment Facility Primary Care Manager Selections:

8.2.1. Prime enrollees selecting an MTF/Clinic primary care manager must be updated in DEERS with the specific MTF/Clinic DMIS-ID for the PCM.

8.2.2. The PCM Location Code will require mandatory entry of '00' for MTF primary care providers. There will be no default to spaces.

8.3. ADP Update Procedures:

8.3.1. Items 8.3.1 through 8.3.6. apply only to the initial load for enrollment based capitation that occurred in 1997. For all Prime enrollees including TPR enrollees resident on DEERS as of the date of this change package, the DMIS-ID and PCM Location Code will have to be researched to ensure that it complies with the instructions above. To do this the contractor must first query DEERS and then their own internal history to determine how the beneficiary's DMIS-ID and PCM location fields appear now for every beneficiary in their region(s). For those records that need to be updated, the new DEERS Adjustment Transaction must be used exactly as stated in Chapter 9, Addendum A. The adjustment transaction is an on-line transaction to DEERS. No cartridge/tape batch updates to DEERS will be accepted.

8.3.2. On the adjustment transaction, the existing DMIS-ID is required as well as the new DMIS-ID, for either the MTF PCM or the network PCM. DEERS will compare the old to the new as one of the cross-check measures to ensure that the correct beneficiary is being updated and that the beneficiary has not moved to a new enrolling region. If a discrepancy occurs in the new DMIS-ID, DEERS will return an error message #34 stating "Invalid Enrolling Organization DMIS-ID." If a discrepancy occurs in the existing DMIS-ID, DEERS will return an error message 36, "Incorrect Old Enrolling Organization on Adjustment Transaction."

8.3.3. As of the date of this change package, regions 9, 10, and 12, are grouped together in DEERS as DMIS-ID 6512. This 6512 DMIS-ID must be updated with 6909, 6910, and 6912, accordingly, for network providers with a PCM Location Code '01.' If MTF/Clinic PCMs also currently show DMIS-ID 6512, these must also be separated into the appropriate MTF/Clinic DMIS-ID with a PCM Location Code '00.' The contractor shall enter DMIS-ID 6512 for regions 9, 10, and 12 on the Adjustment Transaction in the field called "Old Enrolling Organization DMIS-ID." The contractor shall enter either the specific network PCM or MTF/Clinic PCM DMIS-ID in the field called "New Enrolling Organization DMIS-ID."

8.3.4. It is imperative that the effective date on the adjustment transaction be the same as the enrollment date already in DEERS. Do not make the effective date today's date. The effective date is NOT the effective date of the DMIS-ID update. Rather, it is the effective date of the enrollment. **The effective date must equal the enrollment date**. If these dates are not equal, DEERS will return an error code 37 "Incorrect Enrollment Date on Adjustment Transaction."

8.3.5. As stated above, the PCM Location Code requires mandatory entry. If the PCM Location Code is not '00' or '01' an error message will be returned. If '00' does not agree with

an MTF/Clinic DMIS-ID, an error message will be returned as will '01' not agreeing with a network 6900 series DMIS-ID. The error message for any of these discrepant/invalid conditions is #35 "Invalid PCM Location Code."

8.3.6. Once the contractor has completed the necessary programming to correctly align the DMIS-IDs and PCM Location Codes, the contractor will be required to test for a period of 30 days prior to implementation. The contractor will be required to select a variety of Prime production records for DEERS to copy into test. The production SSNs must be reported to TRICARE Management Activity Information Systems for testing on DEERS. When the DEERS copy is made, the last digit of the sponsor's SSN will be converted to '7' in the test environment. The initial realignment of DMIS-IDs and PCMs will not result in a new DEERS history segment. However, any PCM changes made after the initial realignment will result in a new history segment regardless of whether the change is made during a single enrollment period. The new history segment is required to track when a beneficiary changes from a network to an MTF/Clinic PCM or vice versa.

8.3.7. Non-TPR Active Duty Service Member Enrollment - The PCM Location DMIS-ID from 10/1/97 forward must be the valid MTF/Clinic DMIS-ID, it cannot contain PCM Location DMIS-ID values of 6901-6915, 7901-7912, 7916, 8000-8099, or blank. The Enrollment Status Code must = 'Z' for Active Duty Service Member, 'BB' for Medicare Senior Prime, or 'SR' for Supplemental Health Care Program - Referred Care.

8.3.8. TRICARE Prime Remote Active Duty Service Member Enrollment -

8.3.8.1. Enrollment Status Code for the following PCM Location DMIS-IDs from 10/1/97 forward must be 'W'.

8.3.8.2. Regions 1, 2, and 5

8.3.8.2.1. On or after 10/1/97 through 9/30/99, the DMIS-ID for region 1 must be blank, 7901 or 8000-8099, region 2 must be blank, 7902 or 8000-8099, and region 5 must be blank, 7905 or 8000-8099.

8.3.8.2.2. From 10/1/99 forward, the PCM Location DMIS-ID for region 1 must be 7901 or 8000-8099, region 2 must be 7902 or 8000-8099, and region 5 must be 7905 or 8000-8099. Blank will no longer be a valid DMIS-ID.

8.3.8.3. Region 11

8.3.8.3.1. On or after 10/1/97 through 9/30/99, the PCM Location DMIS-ID for region 11 must be 6911 or blank.

8.3.8.3.2. From 10/1/99 forward, the region 11 PCM Location DMIS-ID must be 7911.

8.3.8.4. Regions 3, 4, 6-10, 12

8.3.8.4.1. From 10/1/99 forward the PCM Location DMIS-ID must be 7903, 7904, 7906-7910, 7912, or 7916.

8.3.9. Active Duty Family Member, Retiree, and Retiree Family Member MTF/ Clinic Enrollment -

8.3.9.1. From 10/1/97 forward, the PCM Location DMIS-ID must be a valid MTF/Clinic DMIS-ID. It cannot be a PCM Location DMIS-ID value of 6901-6915, 7901-7912, 7916, 8000-8099, or blank. The Enrollment Status Code must = 'Z' for MTF/Clinic enrolled beneficiaries, 'BB' for TRICARE Senior Prime (TSP) enrollees, or 'SR' for Supplemental Health Care Program.

8.3.10. Active Duty Family Member, Retiree, and Retiree Family Member Network Enrollment - For DEERS:

8.3.10.1. The Enrollment Status Code must be 'U' for all network enrollees for all regions from 10/1/97 forward.

8.3.11. Regions 1, 2, and 5

8.3.11.1. From 10/1/97 forward, the DMIS-ID for region 1 must be 6901 or 8000-8099, region 2 must be 6902 or 8000-8099, and region 5 must be 6905 or 8000-8099.

8.3.11.2. On or after 10/1/97 through 9/30/99, region 2 must be 6501, 6902 or 8000-8099.

8.3.12. Regions 3, 4, 6-15

8.3.12.1. From 10/1/97 forward the PCM Location DMIS-ID must be 6903, 6904, 6906-6915 respectively.

8.3.13. If the TPR service member or family member is enrolled but is not associated with a network provider the PCM Location Code must be blank.

8.3.14. Non-TPR active duty service members must be enrolled with the appropriate MTF or clinic DMIS-ID and the enrollment status code must = 'Z' or 'SR'. This applies to all regions.

Contractor problems and questions shall be reported to TMA for research. The grid below depicts the information in 8.3.7. through 8.3.14. above.

ENROLLEE	DMIS-ID	PCM LOCATION CODE
ADSM and ADFM (MTF/Clinic Enrollee)	MTF/Clinic	00
ADFM (Network Enrollee)	Region 1, 2, or 5 = 8000 series All other regions = 6900 series	01
TPR Enrollee	Region 1, 2, or 5 = 7900 or 8000 series All other regions = 7900 series	01
TPR Enrollee prior to 10/1/99	All regions = Blank or Region 11 = 6911 or Blank	Blank